Supreme Court, U.S.
FILED
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OFFICE OF THE CLERK

NO. _____

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1995

SUSAN L. FIELDS,

Petitioner,

vs.

SECRETARY OF HEALTH AND HUMAN SERVICES,

Respondent.

PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

SUPPLEMENTAL PETITION FOR WRIT OF CERTIORARI

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Pursuant to Rule 14 of the Rules of the United States Supreme Court, the following Administrative Decisions and Judicial Decisions are to be considered as part of Petitioner's Petition for Writ of Certiorari.

Respectfully submitted,

MICHAEL D. PORTNOY
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Social Security Administration
Office of Hearings and Appeals

Name and Address of Claimant:
•Susan Louise Fields
130 North Columbus Ave.
Fremont, OH 43420

NOTICE OF DECISION --- DENIAL
PLEASE READ CAREFULLY

If You Think the Decision is Wrong

- You have the right to appeal. You must file your appeal within 60 days from the date you receive this notice. (The "date you receive notice" means 5 days after the date shown below, unless you show us that you did not receive it within the 5-day period.)

- When you appeal, you request that the Appeals Council review the decision. If the Appeals Council grants your request, it will review the entire record in your case. It will review those parts of the decision which you think are wrong. It will also review those parts which you think are correct and may make them unfavorable or less favorable to you. You will receive a new decision.

- You (or your representative) have to ask for the appeal in writing. You may sign a form HA-520, called "Request for Review by the Appeals Council," or write a letter.

- You may submit your appeal to your local Social Security office, or a hearing office, or mail it directly to the Appeals Council, Office of Hearings and Appeals, P.O. Box 3200, Arlington, VA 22203.

The Appeals Council May Review the Decision Even If You Do Not File an Appeal

- Within 60 days from the date shown below, the Appeals Council may review the decsion (sic) on its own motion. This could change the decision.

- After the 60-day period, the Appeals Council may reopen and revise the decision in certain situations.

- The Appeals Council will notify you if it decides to review the decision on its own motion or to reopen and revise the decision.

Unless you request review within the 60-day period or the Appeals Council reviews the decision on its own motion, you may not obtain a court review of your case (sections 205(g), 1631(c)(3) or 1869(b) of the Social Security Act).

This notice and enclosed copy of
decision mailed

November 26, 1990

cc:
Name and Address of Representative:
- George Fell, Esq.
  3425 Executive Parkway
  Toledo, OH 43606

Form HA-L5023-U7 (7-87)

CLAIMS FOLDER

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Social Security Administration
OFFICE OF HEARINGS AND APPEALS

DECISION

IN THE CASE OF:	CLAIM FOR:
Susan Fields (Claimant)	Period of Disability and Disability Insurance Benefits
	290-42-6916 (Social Security Number)

This case is before the Administrative Law Judge on a request for hearing. The Administrative Law Judge has carefully considered all the documents identified in the record as exhibits, the testimony at the hearing and arguments presented.

ISSUES

The general issues are whether the claimant is entitled to a period of disability and disability insurance benefits under sections 216(i) and 223, respectively, of the Social Security Act, as amended. The Social Security Act defines "disability" as the inability to engage in any substantial gainful activity due to physical or mental impairment(s) which can be expected to either result in death or last for a continuous period of not less than 12 months.

The specific issues are whether the claimant was under a "disability" and, if so, when such disability commenced and the duration thereof; and whether the disability insured status requirements of the Act are met for the purpose of entitlement.

APPLICABLE REGULATIONS AND EVALUATION OF THE EVIDENCE

Pursuant to the Act, the Secretary has established Social Security Administration Regulations No. 4. The regulations provide steps for evaluating disability (20 CFR 404.1520(a)). In addition, a claimant's impairment must meet the 12 month duration requirement before being found disabling. If it is determined that a claimant is or is not disabled at any point in the review, further review is not necessary.

Social Security Administration Regulations No. 4 requires the Administrative Law Judge to consider the following in sequence:

1. An individual who is working and engaging in substantial gainful activity will not be found to be "disabled" regardless of medical findings (20 CFR 404.1520(b));

2. An individual who does not have a "severe impairment" will not be found to be "disabled" (20 CFR 404.1520(c));

3. If an individual is not working and is suffering from a severe impairment which meets the duration requirement and which "meets or equals a listed impairment in Appendix 1 of Subpart P of Regulations No. 4, a finding of "disabled" will be made without consideration of vocational factors (20 CFR 404.1520(d));

4. If an individual is capable of performing work he or she has done in the past, a finding of "not disabled" must be made (20 CFR 404.1520(e));

5. If an individual's impairment is so severe as to preclude the performance of past work, other factors including age, education, past work experience and residual functional capacity must be considered to determine if other work can be performed (20 CFR 404.1520(f)).

The rules set out in Appendix 2 of Subpart P of Regulations No. 4 are considered in determining whether a claimant with exertional impairments is or is not disabled. The regulations also provide that if an individual suffers from a nonexertional impairment as well as an exertional impairment, both are considered in determining residual functional capacity (20 CFR 404.1545).

If a finding of disabled cannot be made based on strength limitations alone, the rules established in Appendix 2 are used as a framework in evaluating "disability." In cases where the individual has solely a nonexertional impairment, a determination as to whether disability exists shall be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2.

The evaluation process described above applies to both physical and mental impairments. In addition, the Regulations require the Administrative Law Judge to follow a special procedure when evaluating the severity of mental impairments. This special procedure requires the use of the form appended to this decision in all cases in which a mental impairment has been found to exist (20 CFR 404.1520a).

The form is used to list the signs, symptoms and other medical findings which establish the existence of the mental impairment. The medical findings are recorded in one or more subsections in Section III of the form. These subsections correspond to the paragraph A criteria for the categories of mental disorders in Appendix 1 of Subpart P, Regulations No. 4, and are known as the "A" criteria.

The form is also used to rate the degree of functional loss resulting from the documented mental impairment(s). There are four areas of function which have been found especially relevant to the ability to work and which correspond to the paragraph B criteria of most of the mental disorders listed in Appendix 1; hence, they are known as the "B" criteria. These areas are: activities of daily living; social functioning; concentration, persistence and pace; and deterioration or decompensation in work or work-life settings. The rating for each of these four areas is compared with the criteria set forth in the Regulations for determining the severity of the mental impairment.

In applying the sequential steps outlined above, the Administrative Law Judge concludes that a decision on whether the claimant is disabled cannot be made based on work activity or on medical facts alone. Moreover, the record establishes that the claimant cannot perform her past relevant work. However, considering the claimant's residual functional capacity and her age, education, and past work experience, the Administrative Law Judge further concludes that there are other jobs which the claimant can perform and that such jobs exist in significant numbers in the national economy. Consequently,

it must be found that the claimant is not disabled within the meaning of the Social Security Act.

EVALUATION OF THE EVIDENCE

The claimant filed an application for disability insurance benefits on September 29, 1989, alleging "disability" since April 13, 1988 (Exhibit 1) because of back pain (Exhibit 10). The claimant meets the insured status requirements of the Act on the date of alleged onset of disability and through September 30, 1993 (Exhibit 8). Claimant's application was denied; she requested a hearing and appeared for hearing and was represented by Fred Burkholder, Attorney-at-Law.

The claimant was born December 2, 1952, and is 38 years old (Exhibit 1). She has a greater than 12 year education and has past relevant work experience as a factory laborer and quality control inspector (Exhibits 9, 10, 32 and vocational expert testimony infra).

In reports prepared for the Administration, claimant said that her back pain is so severe that she can hardly stand, sit or walk without changing positions; that her spine "burns" and is extremely tender to touch; and that she is physically and emotionally depressed (Exhibits 10 and 11). However, claimant indicated further that she does not let her depression restrict her, and she attributes her major limitations to physical impairment (Exhibit 12). Claimant has indicated alternately that she takes no medications because she is allergic to them (Exhibit 13), and that she takes Demerol for pain and Ceclor for an infection (Exhibit 32).

At the hearing, claimant reiterated "disability" since April 1988 because of back pain. Claimant said that she has pain in her neck, mid back and lower back radiating up from the buttocks to the neck. Claimant changed her allegations regarding medication yet again, indicating that she takes no prescription medication whatsoever, although she says that she has undergone evaluation and treatment at a local pain clinic. Claimant estimates that because of her back pain she can lift no more than 20 pounds, stand one hour and sit one hour. She also alleges that it is easier for her to walk than to stand. Claimant reports further treatment in the form of a back brace and TENS unit, although she does not use ambulatory aids.

With respect to daily functioning, claimant acknowledges that she maintains her personal needs; that she does housework, including cooking, washing dishes, dusting, sweeping, vacuuming, washing clothes, making the bed and going shopping; that she goes for walks and drives; that she visits friends, writes as a hobby, goes swimming and goes out to dinner; and that she gets along with other people very well. Claimant denies receiving any formal mental health care or taking any medication for mental/emotional disorder.

The evidence of record does not sustain claimant's allegations that she has symptoms due to medical determinable impairments that preclude her from performing substantial gainful activity; thus, her application must be denied.

Specifically, claimant does have a history of a remote (1980) laminectomy and discectomy at L4 to L5 and L5 to S1 because of a bulging (but not herniated) intervertebral disc (Exhibit 17), and a second hospitalization in 1984 to undergo spinal fusion at L5 to S1 because of recurrent of symptoms (Exhibit 14). However, claimant has not been hospitalized for back impairment since then; she did undergo hernia repair in July 1990 (Exhibit 36), although attending physician Louis Carvalho, M.D., indicated that claimant was able to resume her normal activities following surgery (Exhibit 38).

Instead, claimant's treatment for back pain has been conservative. This includes evaluation and treatment at Central Park West Rehabilitation Center (Exhibit 34) and at St. Charles Hospital Pain Management Center (Exhibit 15). Records from these facilities show claimant to have functional range of motion of the spine, upper extremities and lower extremities, and contain no findings of anatomic reflex abnormality, sensory deficit, motor weakness or atrophy.

Claimant has also undergone chiropractic manipulation, as evidenced by a series of reports submitted by David Fields, D.C. Dr. Fields, who first examined the claimant in May 1989 (over one year after her alleged onset of "disability") reports claimant to have limitation of motion of the spine but also reports x-rays to be negative for recent fracture, gross osteopathology or abnormalities other than for decreased disc space at L5 to S1. He notes claimant's allegations that she is "in constant pain," although he opined that claimant was responding to chiropractic manipulation. He said initially that claimant could do "light to moderate physical work, four to six hours a day" (Exhibit 16), and that claimant had substantial overall improvement in her ability to function (Exhibit 25). In a more recent report prepared for

claimant's counsel, Dr. Fields changes his opinion entirely to the point that he questioned claimant's ability to perform any type of work, although in the same report he opined that claimant could lift up to 20 pounds at a time and stand and walk five hours per eight hour day. He also opined that claimant has "structural instability" of the lumbar and lumbosacral spine (Exhibit 37), although the findings he offers wholly fails to support this conclusion. Thus, the undersigned rejects the opinion of Dr. Fields with respect to claimant's "disability," although resort need not be made to Regulation 404.1527 as Dr. Fields is not a physician.

Claimant has also undergone evaluation in conjunction with her application for Worker's Compensation payments (Exhibit 18). These include evaluations by Michael Gordon, M.D. (Exhibit 33) and Ira Weiden, M.D. (Exhibit 35).

Dr. Gordon noted that claimant reinjured her back on April 13, 1988 (although as noted supra, the record is devoid of medical treatment corresponding to that date). He also noted that claimant underwent an extensive work-up including normal CT scan, MRI scan and myelogram, and said that no signs for radiculopathy or surgical problems were seen. (The undersigned notes that, despite the welter of evidence submitted by counsel, none of these diagnostic studies is contained in the record.) Dr. Gordon reviewed claimant's symptoms and reported physical examination findings to show no signs of sinovitis, although claimant had trigger point tenderness. He characterized claimant's lumbar range of motion as moderately restricted to flexion and extension, but lateral bending was normal. Neurologic examination revealed a "stiff gait;" the claimant's reflexes and muscle strength was normal, and she was able to walk on heels and toes and arise from a chair without difficulty. Dr. Gordon concluded that claimant has a history that is "very typical" for fibrositis involving her entire spine, although there is nothing in the record to suggest an inflammatory process. He also speculated that claimant's physical symptoms may be complicated by mental impairment, considering her allegations of pain with associated anxiety, depression, irritable bowel syndrome and sleep disturbance despite a relatively benign appearing exam (Exhibit 33).

Similar physical findings were offered by Dr. Weiden, although he made no mention of mental impairment. He reviewed of the claimant's history and complaints and said that claimant had generalized fibromyalgia with severe muscle spasm from the neck down to the low back and gluteal regions, with negative straight leg raising and no apparent reflex abnormality, sensory deficit

or muscle spasm except for that due to fibromyalgia. He also noted that claimant had marked reduction in back range of motion; "almost any movement gave her pain." However, claimant had normal range of motion of the neck and right shoulder, despite a remote (1978) history of dislocation. Dr. Weiden also reported that MRI scans, CT scans and myelograms to be negative (again, as noted supra, apparently counsel has not seen fit to submit this evidence for the record.) Dr. Weiden concluded that claimant has a diffuse, generalized fibromyalgia with some evidence of left L5 nerve root irritation as shown by one inch atrophy of the left thigh and one/third inch atrophy of the left calf, but with no evidence of active disease at this time. Dr. Weiden opined that claimant's chances of getting back to work are "quite poor," although he appears to base this largely on claimant's symptoms and "her own attitude;" however he did opine that most of claimant's "chronic disability" is due to diffuse fibromyalgia (Exhibit 35). The undersigned has considered the opinion of Dr. Weiden, but rejects it under authority of Regulation 404.1527, as it is not based adequately on objective findings but rather largely on claimant's subjective symptomatology and her own unsupported allegations.

Further support for the view that claimant retains the functional capacity to perform substantial gainful activity is contained in a consultative examination done by Rekja Trivedi, M.D. Dr. Trivedi reviewed claimant's history and complaints, and reported physical examination findings to show restricted (but functional) motion of the dorsolumbar spine, full range of motion of the cervical spine and full range of motion of the upper extremities and lower extremities. He said that claimant has no reflex abnormality, muscle spasm, sensory deficit or atrophy, and that x-rays show only mild narrowing at L5 to S1 with no evidence of fracture, dislocation or destructive process. He further noted that claimant walks normally and independently, and concluded that physical examination reveals no evidence of nerve root compression (Exhibit 19).

In order to resolve the discrepancy in the evidence of record, testimony was obtained from two medical experts and a vocational expert.

The first medical expert, Frank Cox, M.D., Board-certified in internal medicine, testified with respect to physical impairment and said that claimant has a history of degenerative disc disease for which she underwent surgery in 1980 and in 1984 (fusion), although findings do not show nerve root involvement. He noted further that MRI scans, CT scan and myelograms (not

contained in the record) are reported to be negative, and that x-rays show no significant structural changes of the spine. He concluded that claimant has fibromyalgia and that there is not neurologic pathway to explain the report of Dr. Weiden (Exhibit 35) and of the claimant that she has pain from the buttocks to the neck. He concluded that claimant's impairments, considered singly and in combination, do not meet or equal the requirements of the Listing of Impairments of Appendix 1, Subpart P, Social Security Regulations No. 4, and that the objective records demonstrate no significant impairment. He concluded that claimant should be able to do "at least" medium work as that term is defined in Regulation 404.1567.

Godfried Spring, M.D., Board-certified in psychiatry, appeared at the hearing as a Medical Expert concerning mental impairment. He noted that claimant has never had formal, ongoing psychiatric care or treatment with psychotrophic medications, although she has participated in a pain management program to which she responded quite well. He indicated that psychological assessments done in conjunction with claimant's evaluation at these facilities did not include any specific psychiatric diagnosis, although he indicated that claimant's unrealistic interpretation of physical signs or sensations is consistent with a somatoform disorder, best diagnosed as "psychological factors affecting physical condition." Dr. Spring reviewed further claimant's functional limitations secondary to mental impairment, indicating that claimant has slight restriction of activities of daily living, slight difficulties in maintaining social functioning and few (seldom) deficiencies of concentration, persistence or pace; she has never had an episode of deterioration or decompensation in work or work-like settings. He concluded that claimant's condition does not meet or equal the requirements of the Listing of Impairments of Appendix 1, Subpart P, Social Security Regulations No. 4, and that on a psychiatric basis she would be limited to performing low stress, simple tasks (20 CFR 404.1545).

Mary Smith, M. Ed., appeared at the hearing as a Vocational Expert and testified that claimant's past work work as a factory laborer was light and unskilled and that her work as a quality control inspector was light and semi-skilled (20 CFR 404.1565, 404.1567, 404.1568). A hypothetical question was presented to the Vocational Expert in which she was asked to assume an individual of the claimant's age, education and work experience, having the residual functional capacity to perform medium work (20 CFR 404.1567) with the additional limitations that she could perform low stress, simple, repetitive tasks (20 CFR 404.1545). The Vocational Expert responded that such an

individual could perform jobs including dining room attendant, counter supply worker, cook helper, and food counter worker, and testified as to the numbers in which these jobs exist in the economy, which the undersigned finds to be "significant" under Regulation 404.1566.

Accordingly, in applying sequential evaluation (20 CFR 404.1520), it is found that claimant is not working and has not engaged in substantial gainful activity since April 13, 1988 (20 CFR 404.1520(b)). It is further found that claimant has severe fibromyalgia, status post remote laminectomy, discectomy and fusion for degenerative disc disease; and psychological factors affecting physical condition (20 CFR 404.1520(c)), but that her impairments are not attended by objective findings that meet or equal the requirements of the Listing of Impairments of Appendix 1, Subpart P, Social Security Regulations No. 4 (20 CFR 404.1520(d)). However, because of the claimant's stress limitations, she cannot return to her past relevant work as a factory laborer and quality control inspector (20 CFR 404.1520(e)).

Once a claimant has established that she cannot perform her past relevant work because of her impairments, the burden shifts to the Secretary to show that there are other jobs existing in significant numbers in the national economy which she can perform, consistent with her medically determinable impairments, functional limitations, age, education and work experience.

However, the undersigned finds that claimant retains the functional capacity to perform jobs which exist in significant numbers in the national economy and regions thereof (20 CFR 404.1566). Thus, she is capable of engaging in substantial gainful activity and is "not disabled" (20 CFR 404.1520(f)).

As noted supra, claimant has a history of remote laminectomy and discectomy in 1980 (Exhibit 17) and of spinal fusion in 1984 (Exhibit 14) for degenerative disc disease of the spine. However, claimant continued working until April 1988, and despite the report of reinjury in April 1988 (Exhibits 33, 34 and 35), the evidence of record does not show evaluation or treatment on an outpatient basis, much less hospitalization or sophistocated (sic) work-up at or about that time. Indeed, claimant's recent hospitalization in July 1990 was for hernia repair (Exhibit 36), which was accomplished without residual functional limitations arising therefrom (Exhibit 38).

Claimant has apparently undergone diagnostic studies including MRI scan, CT scan and myelograms, all of which have been reported by Drs. Gordon

(Exhibit 33) and Weiden (Exhibit 35) to be normal, although the actual diagnostic studies are not contained in the record despite the volume of evidence submitted by counsel, including six exhibits comprising 35 pages that were submitted on the day of the hearing (Exhibits 33 through 38).

What is contained in the record establishes that claimant has undergone evaluation and treatment at pain management centers including Central Park West Rehabilitation Center (Exhibit 34) and St. Charles Hospital Pain Management Center (Exhibit 15). These facilities show claimant to have limitation of the motion of the spine, but no gait antalgia, associated neurologic impairment indicative of nerve root compression, or other conditions that would merit more aggressive therapy.

Claimant has also undergone chiropractic manipulation, as evidenced by a series of internally discrepant reports submitted by David Fields, D.C. Specifically, Dr. Fields reports initially that claimant has limitation of motion of the lumbar spine but he reports no neurological impairment, joint instability or x-ray evidence showing any abnormalities other than decreased disc space at L5 to S1. He reports that claimant could perform "light to moderate physical work, four to six hours a day" (Exhibit 6), and that claimant has experienced substantial overall improvement in her ability to function (Exhibit 25). However, in a report recently submitted by counsel, Dr. Fields questioned claimant's ability to perform any type of work, although in the same report he opines that claimant can lift up to 20 pounds at a time and walk and stand five hours per day, although the findings he offers in support of his opinion are deficient (Exhibit 27). Thus, as noted supra, the undersigned rejects Dr. Fields opinion without invoking Regulation 404.1527, as Dr. Fields is a chiropractor and not a physician.

However, the undersigned does invoke Regulation 404.1527 to reject the opinion of Dr. Weiden, that, in effect, claimant could not return to work. He bases this on claimant's chronic diffuse fibromyalgia, although this appears to be largely on claimant's symptoms and on his opinion that claimant's "attitude" is "quite poor." He reports claimant to have one inch left thigh atrophy and one/third inch left calf atrophy accompanied by muscle spasms due to fibromyalgia and limitation of motion of the spine, although he reports no reflex abnormality, sensory deficit or motor weakness corresponding to a dermatonal distribution (Exhibit 35), and as noted by Dr. Cox, there is no neurological pathway in the human anatomy to explain pain radiating from the buttocks to the neck (testimony supra). Indeed, no such findings are offered

by Dr. Gordon, who also notes that diagnostic studies (not contained in the record) are negative for radiculopathy or a surgical problem and who reports that claimant has trigger point tenderness and moderately restricted lumbar flexion and extension but normal lateral bending, full range of motion of all other joints without synovitis, and no neurologic impairment. This led to Dr. Gordon's opinion that claimant's pain symptoms, combined with associated anxiety, depression, irritable bowel syndrome and sleep disturbance, are consistent with fibrositis in light of a relatively benign-appearing exam (Exhibit 33).

Furthermore, as noted supra, a thorough consultative examination, done by Rekja Trivedi, M.D., shows no atrophy whatsoever; no reflex abnormality, sensory deficit, motor weakness or spasm; and only mild to moderate limitation of motion of the dorsolumbar spine with full range of motion of the cervical spine, upper extremities and lower extremities. He further reports claimant to have a normal, unassisted gait without signs of joint instability or inflammation. He notes further that x-rays show only mild narrowing at L5 to S1 with no fracture, dislocation or distruptive (sic) process, leading to his conclusion that claimant has no evidence of nerve root compression (Exhibit 19).

Symptoms such as pain are the individual's own preceptions of the effects of an impairment(s). Because of their subjective characteristics and the absence of reliable techniques for measurement, symptoms are difficult to prove or to or quantify. The guidelines for evaluation of pain are set forth in Social Security 88-13 and Regulation 404.1529. The claimant's allegations in this regard are entitled to preceptible weight where they are properly and adequately documented by the medical evidence. Objective evidence such as muscle atrophy from nonuse, muscle spasm, reduced joint motion, and sensory and motor disruption should be considered where applicable. However, where the alleged or reported symptoms exceed the expected level of pain and/or dysfunction, it is important to consider such factors as (1) nature, location, onset, duration, frequency, radiation and intensity of the pain; (2) precipitating and aggravating factors such as movement or activity; (3) type, doseage, effectiveness, and adverse side-effects of pain medication; (4) treatment for relief of pain other than medication; (5) functional restrictions; and (6) the claimant's level of activities. It is useful at times to consider observations of the claimant by the undersigned at the hearing and by examining doctors. Finally, the credibility of the claimant should also be taken into consideration.

As noted supra, the record contains none of the indiscia (sic) of physical impairment that would support claimant's subjective allegations that, in effect, she has debilitating, devastating, relentless, incapacitating pain. Furthermore, as noted supra, claimant noted initially that she took no medications (Exhibit 13), then said that she took Demerol and Ceclor (Exhibit 32) and then testified at the hearing that she took no medication (testimony). Claimant's treatment has been conservative; her back surgeries were in 1980 and in 1984, long before her alleged onset of "disability" (Exhibits 14 and 17). The claimant has undergone evaluation and treatment at local pain management centers (Exhibits 15 and 24) and has received chiropractic manipulation (Exhibits 16, 25 and 37) with at least some success. Claimant acknowledged also that she last used a back brace about a year ago and that she has a TENS unit but cannot put it on herself.

Additionally, claimant acknowledges that she maintains her personal needs; does housework including cooking, washing dishes, dusting, sweeping, vacuuming, washing clothes and making the bed; that she goes shopping and does yardwork; and that she goes for walks and drives, gets along with other people well and acknowledges that she has never had formal mental health care or received psychotropic medication. Claimant acknowledges also that she visits friends, goes out to dinner, writes as a hobby, and occasionally goes swimming.

Accordingly, considering claimant's subjective symptomatology according to the principles of Social Security 88-13, and considering further substantial evidence in the form of objective medical and clinical findings, substantiated medical opinion, testimony of two Medical Experts and a Vocational Expert, and considering claimant's own acknowledgements concerning her daily functioning and treatment modalities, the undersigned concludes that claimant can perform medium work (20 CFR 404.1567), with additional limitations that she perform low stress work involving simple, repetitive tasks (20 CFR 404.1545).

Furthermore, in reviewing the claimant's vocational factors, the undersigned notes that the claimant is 38 years old, which is defined as a younger individual (20 CFR 404.1563), and that she has a greater than 12 year education (20 CFR 404.1564). The claimant does not have any acquired work skills which are transferable to the skilled ar (sic) semi-skilled work functions of other work (20 CFR 404.1568).

Based on an exertional capacity for medium work, and the claimant's age, education, and work experience, Section 404.1569 and Rules 203.28 and 203.29, Table No. 3, Appendix 2, Subpart P, Regulations No. 4 would direct a conclusion of "not disabled."

Furthermore, although the claimant's additional limitations do not allow her to perform the full range of medium work, using the above-cited rules as a framework for decisionmaking, there are a significant number of jobs in the national economy which she could perform. Examples of such jobs include dining room attendant, counter supply worker, cook helper, kitchen helper and food counter worker. These jobs exist in significant numbers in the national economy and regions thereof (20 CFR 404.1566).

Thus, since claimant retains the functional capacity to perform jobs which exist in significant numbers in the national economy and regions thereof, she is capable of engaging in substantial gainful activity and is "not disabled" (20 CFR 404.1520(f)).

It is found that the claimant was not under a "disability" as defined in the Social Security Act, at any time through the date of this decision.

FINDINGS

After careful consideration of the entire record, the Administrative Law Judge makes the following findings:

1. The claimant met the disability insured status requirements of the Act on April 13, 1988, the date the claimant stated she became unable to work, and continues to meet them through September 30, 1993.

2. The claimant has not engaged in substantial gainful activity since April 13, 1988.

3. The medical evidence establishes that the claimant has severe fibromyalgia, status post remote laminectomy, discectomy and fusion for degenerative disc disease; and psychological factors affecting physical condition, but that she does not have an impairment or combination of impairments listed in, or medically equal to one listed in to Appendix 1, Subpart P, Regulation No. 4.

4. Claimant's allegations of disabling pain and limitation of function are distinctly not credible, and are not supported by substantial evidence int he form of objective medical clinical findings, substantiated medical opinion, expert testimony and claimant's own acknowledgements concerning her daily functioning and treatment modalities (Social Security Ruling 88-13). Claimant does not have pain or limitation of function due to medically determinable impairments that would preclude her from performing substantial gainful activity.

5. The claimant has the residual functional capacity to perform medium work (20 CFR 404.1567), with additional limitations that she perform low stress work involving simple, repetitive tasks (20 CFR 404.1545).

6. The claimant is unable to perform her past relevant work as a laborer and quality control inspector because of her stress limitations.

7. The claimant is 38 years old, which is defined as a younger individual (20 CFR 404.1563).

8. The claimant has a greater than 12 year education (20 CFR 404.1564).

9. The claimant does not have any acquired work skills which are transferable to the skilled or semi-skilled work functions of other work (20 CFR 404.1568).

10. Based on an exertional capacity for medium work, and the claimant's age, education, and work experience, Section 404.1569 and Rules 203.28 and 203.29, Table No. 3, Appendix 2, Subpart P, Regulations No. 4 would direct a conclusion of "not disabled."

11. Although the claimant's additional limitations do not allow her to perform the full range of medium work, using the above-cited rules as a framework for decisionmaking, there are significant number of jobs in the national economy which she could perform. Examples of such jobs include dining room attendant, counter supply worker, cook helper, kitchen helper, and food counter worker. Such jobs exist in significant number in the national economy and regions thereof (20 CFR 404.1566).

12. The claimant was not under a "disability," as defined in the Social Security Act, at any time through the date of this decision (20 CFR 404.1520(f)).

DECISION

It is the decision of the Administrative Law Judge that, based on the application filed on September 29, 1989, the claimant is not entitled to a period of disability or disability insurance benefits under Sections 216(i) and 223, respectively, of the Social Security Act, as amended.

Richard C. Mesrobian
Administrative Law Judge

Dated: November 26, 1990

Form HA-514-C6 (10-87)

CLAIMS FOLDER

DEPARTMENT OF HEALTH & HUMAN SERVICES

Social Security Administration

Refer to: 290-42-6916

Office of Hearings and Appeals
1127 Euclid Avenue, Room 1150
Cleveland, Ohio 44115

Susan Louise Fields
5713 Tibaron Lane Suite 106
Toledo, Ohio 43615

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- You have the right to appeal. You must file your appeal within 60 days from the date you receive this notice. The "date you receive notice" means 5 days after the date shown below, unless you show us that you did not receive it within the 5-day period.)

- When you appeal, you request that the Appeals Council review the decision. If the Appeals Council grants your request, it will review the entire record in your case. It will review those parts of the decision which you think are wrong. It will also review those parts which you think are correct and may make them unfavorable or less favorable to you. You will receive a new decision.

- You (or your representative) have to ask for the appeal in writing. You may sign a form HA-520, called "Request for Review by the Appeals Council," or write a letter.

- You may submit your appeal to your local Social Security office, or a hearing office, or mail it directly to the Appeals Council, Office of Hearings and Appeals, P.O. Box 3200, Arlington, VA 22203.

The Appeals Council May Review the Decision Even If You Do Not File an Appeal

- Within 60 days from the date shown below, the Appeals Council may review the decision on its own motion. This could change the decision.

- After the 60-day period, the Appeals Council may reopen and revise the decision in certain situations.

- The Appeals Council will notify you if it decides to review the decision on its own motion or to reopen and revise the decision.

Unless you request review within the 60-day period or the Appeals Council reviews the decision on its own motion, you may not obtain a court review of your case (sections 205(g), 1631(c)(3) or 1869(b) of the Social Security Act).

This notice and enclosed copy of
decision mailed

May 6, 1992

cc:
Name and Address of Representative:
•
George Fell
Attorney-at-Law
3425 Executive Parkway, #207
Toledo, OH 43606

Replaces Form HA-L5023-U7

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Social Security Administration
OFFICE OF HEARINGS AND APPEALS

DECISION

IN THE CASE OF	CLAIM FOR
Susan L. Fields (Claimant)	Period of Disability and Disability Insurance Benefits
_____ (Wage Earner)	290-42-6916 (Social Security Number)

This case is before the Administrative Law Judge based upon an Appeals Council Order dated August 9, 1991, which vacated the prior Administrative Law Judge decision dated November 26, 1990, and which remanded this case for further proceedings, including a new decision.

The Appeals Council directed that the undersigned obtained any available updated reports from all treating sources and a mental status consultative examination with psychological testing in order to ascertain the severity of claimant's mental impairment.

Additional evidence, including the consultative examination, was obtained and claimant appeared at the Supplemental Hearing held in Toledo, Ohio on April 23, 1992, represented by Fred Burkholder, Attorney-at-Law.

Additionally, Medical Expert testimony was obtained from Frank Cox, M.D. (Board-certified in internal medicine) and Robert Walden, M.D. (Board-certified in psychiatry and neurology), Vocational Expert testimony was obtained from Karen MacGuffie, M.A.

ISSUES

The general issues are whether the claimant is entitled to a period of disability and disability insurance benefits under Sections 216(i) and 223, respectively,

of the Social Security Act, as amended. The Social Security Act defines "disability" as the inability to engage in any substantial gainful activity due to physical or mental impairment(s) which can be expected to either result in death or last for a continuous period of not less than 12 months.

The specific issues are whether the claimant was under a "disability" and, if so, when such disability commenced and the duration thereof; and whether the disability insured status requirements of the Act are met for the purpose of entitlement.

APPLICABLE REGULATIONS

Pursuant to the Act, the Secretary has established Social Security Administration Regulations No. 4. The regulations provide steps for evaluating disability (20 CFR 404.1520(a)). In addition, a claimant's impairment must meet the 12 month duration requirement before being found disabling. A set order is followed to determine whether an individual is disabled. If it is determined that a claimant is or is not disabled at any point in the review, further review is not necessary.

Social Security Administration Regulations No. 4 requires the Administrative Law Judge to consider the following in sequence:

1. An individual who is working and engaging in substantial gainful activity will not be found to be "disabled" regardless of medical findings (20 CFR 404.1520(b));

2. An individual who does not have a "severe impairment" will not be found to be "disabled" (20 CFR 404.1520(c));

3. If an individual is not working and is suffering from a severe impairment which meets the duration requirement and which "meets or equals a listed impairment in Appendix 1 of Subpart P of Regulations No. 4, a finding of "disabled" will be made without consideration of vocational factors (20 CFR 404.1520(d));

4. If an individual is capable of performing work he or she has done in the past, a finding of "not disabled" must be made (20 CFR 404.1520(e));

5. If an individual's impairment is so severe as to preclude the performance of past work, other factors including age, education, past work experience and residual functional capacity must be considered to determine if other work can be performed (20 CFR 404.1520(f)).

The rules set out in Appendix 2 of Subpart P of Regulations No. 4 are considered in determining whether a claimant with exertional impairments is or is not disabled. The regulations also provide that if an individual suffers from a nonexertional impairment as well as an exertional impairment, both are considered in determining residual functional capacity (20 CFR 404.1545). If a finding of disabled cannot be made based on strength limitations alone, the rules established in Appendix 2 are used as a framework in evaluating "disability." In cases where the individual has solely a nonexertional impairment, a determination as to whether disability exists shall be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2.

The evaluation process described above applies to both physical and mental impairments. In addition, the Regulations require the Administrative Law Judge to follow a special procedure when evaluating the severity of mental impairments. This special procedure requires the use of the form appended to this decision in all cases in which a mental impairment has been found to exist (20 CFR 404.1520a).

The form is used to list the signs, symptoms and other medical findings which establish the existence of the mental impairment. The medical findings are recorded in one or more subsections in Section III of the form. These subsections correspond to the paragraph A criteria for the categories of mental disorders in Appendix 1 of Subpart P, Regulations No. 4, and are known as the "A" criteria.

The form is also used to rate the degree of functional loss resulting from the documented mental impairment(s). There are four areas of function which have been found especially relevant to the ability to work and which correspond to the paragraph B criteria of most of the mental disorders listed in Appendix 1; hence, they are known as the "B" criteria. These areas are: activities of daily living; social functioning; concentration, persistence and pace; and deterioration or decompensation in work or work-life settings. The rating for each of these four areas is compared with the criteria set forth in the regulations for determining the severity of the mental impairment.

EVALUATION OF THE EVIDENCE

The claimant filed an application for Disability Insurance Benefits on September 29, 1989, alleging "disability" since April 13, 1988 (Exhibit 1) because of back pain (Exhibit 10). The claimant meets the insured status requirements of the Act on the date of alleged onset of disability and thorough (sic) September 30, 1993 (Exhibit 8).

The claimant was born December 2, 1952, and is 39 years old (Exhibit 1). She has a greater than 12 year education and has past relevant work experience as a handpacker, material handler and inspector (Exhibits 9, 10, 32, 40 and Vocational Expert testimony infra).

In reports prepared for the Administration, claimant said that her back pain is so severe that she can hardly stand, sit or walk without changing positions; that her spine "burns" and is extremely tender to touch; and that she is physically and emotionally depressed (Exhibits 10 and 11). However, claimant indicated further that she does not let her depression restrict her, and she attributes her major limitations to physical impairment (Exhibit 12). Claimant has indicated alternately that she takes no medications because she is allergic to them (Exhibit 13), and that she takes Demerol for pain and Ceclor for a infection (Exhibit 32). More recently, claimant reported taking Voltaren, Prozac and Ibuprofen (Exhibit 40).

At the prior hearing, claimant reiterated "disability" since April 1988 because of back pain. Claimant said that she has pain in her neck, mid back and lower back, radiating up from the buttocks to the neck. Claimant changed her allegations regarding her medication yet again, indicating that she takes no prescription medication whatsoever, although she says that she has undergone evaluation and treatment at a local pain clinic. Claimant estimated that because of her back pain she can lift no more than 20 pounds, stand one hour and sit one hour. She also alleged that it is easier for her to walk than to stand. Claimant reports further treatment in the form of a back brace and TENS unit, although she does not use ambulatory aids.

With respect to daily functioning, claimant acknowledged that she maintains her personal needs; that she does housework, including cooking, washing dishes, dusting, sweeping, vacuuming, washing clothes, making the bed and going shopping; that she goes for walks and drives; that she visits friends, writes as a hobby, goes swimming and goes out to dinner; and that she gets

along with other people very well. Claimant denied receiving any formal mental health care or taking any medication for mental/emotional disorder.

At the Supplemental Hearing, claimant reiterated excruciating, debilitating, devastating, relentless, rending pain, radiating from her lower back up to her neck. Claimant modified her allegations concerning prescription medication, however, indicating that she was taking no prescription medication prior to March 26, 1992. She reported currently that she uses Premarin, Zolost, and Zantac, and did not indicate either that this medication was ineffective or resulted in adverse side-effects of functional significance. Claimant said further that she can walk four miles independently, pick up 15 pounds, stand one half hour and sit one-half to one hour. Claimant said that she has been prescribed a TENS unit, but needs help to do it. Claimant indicated also that she maintains her personal needs, cooks, washes dishes, dusts, sweeps, vacuums, washes clothes, makes the bed, goes shopping, reads the Bible, writes as a hobby, goes for walks and drives, attends church regularly, rides a bicycle, watches tapes on television and goes out to dinner occasionally. Claimant indicated also that she receives approximately $133 per week in Workers' Compensation payments.

The undersigned has again considered claimant's subjective allegations according to the principles of Social Security Ruling 88-13, which in turn involves a thorough review of the objective medical and clinical findings, substantiated medical opinions, testimony of four Medical Experts at two hearings and two Vocational Experts at two hearings, and has considered the arguments of counsel (Exhibits 39 and 44). Upon this review, the undersigned finds that claimant retains sufficient residual functional capacity to perform her vocationally relevant past work. Thus, her claim remains denied, albeit on a different regulatory basis (20 CFR 404.1520(e)).

Specifically, claimant does have a history of a remote (1980) laminectomy and discectomy at L4 to L5 and L5 to S1 because of a bulging (but not herniated) intervertebral disc (Exhibit 17), and a second hospitalization in 1984 to undergo spinal fusion at L5 to S1 because of recurrent of symptoms (Exhibit 14). However, claimant has not been hospitalized for back impairment since then; she did undergo hernia repair in July 1990 (Exhibit 36), although attending physician Louis Carvalho, M.D., indicated that claimant was able to resume her normal activities following surgery (Exhibit 38).

The claimant's treatment for back pain since then has been conservative. This includes evaluation and treatment at Central Park West Rehabilitation Center (Exhibit 34) and at St. Charles Hospital Pain Management Center (Exhibit 15). Records from these facilities show claimant to have functional range of motion of the spine, upper extremities and lower extremities, and contain no findings of anatomic reflex abnormality, sensory deficit, motor weakness or atrophy.

Claimant has also undergone chiropractic manipulation, as evidenced by a series of reports submitted by David Fields, D.C. Chiropractor Fields, who first examined the claimant in May 1989 (over one year after her alleged onset of "disability"), reported claimant to have limitation of motion of the spine, but also reported x-rays to be negative for recent fracture, gross osteopathology or abnormalities other than for decreased disc space at L5 to S1. He noted claimant's allegations that she is "in constant pain," although he opined that claimant was responding to chiropractic manipulation. He said initially that claimant could do "light to moderate physical work, four to six hours a day" (Exhibit 16), and that claimant had substantial overall improvement in her ability to function (Exhibit 25). In a more recent report prepared for claimant's counsel, Chiropractor Fields changed his opinion entirely to the point that he questioned claimant's ability to perform any type of work, although in the same report he opined that claimant could lift up to 20 pounds at a time and stand and walk five hours per eight hour day. He also opined that claimant has "structural instability" of the lumbar and lumbosacral spine (Exhibit 37), although the findings he offered wholly fails to support this conclusion. Thus, the undersigned rejects the opinion of Chiropractor Fields with respect to claimant's "disability," although resort need not be made to Regulation 404.1527 as Chiropractor Fields is not a physician.

Claimant has also undergone evaluation in conjunction with her application for Worker's Compensation payments (Exhibit 18). These include evaluations by Michael Gordon, M.D. (Exhibit 33) and Ira Weiden, M.D. (Exhibit 35).

Dr. Gordon noted that claimant reinjured her back on April 13, 1988 (although as noted supra, the record is devoid of medical treatment corresponding to that date). He also noted that claimant underwent an extensive work-up including normal CT scan, MRI scan and myelogram, and said that no signs for radiculopathy or surgical problems were seen. (The undersigned notes that, despite the welter of evidence submitted by counsel, none of these diagnostic studies is contained in the record.) Dr. Gordon

reviewed claimant's symptoms and reported physical examination findings to show no signs of synovitis, although claimant had trigger point tenderness. He characterized claimant's lumbar range of motion as moderately restricted to flexion and extension, but lateral bending was normal. Neurologic examination revealed a "stiff gait;" the claimant's reflexes and muscle strength was normal, and she was able to walk on heels and toes and arise from a chair without difficulty. Dr. Gordon concluded that claimant has a history that is "very typical" for fibrositis involving her entire spine, although there is nothing in the record to suggest an inflammatory process. He also speculated that claimant's physical symptoms may be complicated by mental impairment, considering her allegations of pain with associated anxiety, depression, irritable bowel syndrome and sleep disturbance despite a relatively benign-appearing exam (Exhibit 33).

Similar physical findings were offered by Dr. Weiden, although he made no mention of mental impairment. He reviewed of the claimant's history and complaints and said that claimant had generalized fibromyalgia with severe muscle spasm from the neck down to the low back and gluteal regions, with negative straight-leg raising and no apparent reflex abnormality, sensory deficit or muscle spasm except for that due to fibromyalgia. He also noted that claimant had marked reduction in back range of motion; "almost any movement gave her pain." However, claimant had normal range of motion of the neck and right shoulder, despite a remote (1978) history of dislocation. Dr. Weiden also reported that MRI scan, CT scan and myelogram were negative (again, as noted supra, apparently counsel has not seen fit to submit this evidence for the record.) Dr. Weiden concluded that claimant has a diffuse, generalized fibromyalgia with some evidence of left L5 nerve root irritation as shown by one inch atrophy of the left thigh and one/third inch atrophy of the left calf, but with no evidence of active disease at this time. Dr. Weiden opined that claimant's chances of getting back to work are "quite poor," although he appears to base this largely on claimant's symptoms and "her own attitude;" however he did opine that most of claimant's "chronic disability" is due to diffuse fibromyalgia (Exhibit 35). The undersigned has considered the opinion of Dr. Weiden, but rejects it under authority of Regulations 404.1527, as it is not based adequately on findings but rather largely on claimant's subjective symptomatology and her own unsupported allegations.

Further support for the view that claimant retains the functional capacity to perform work is contained in a consultative examination done by Rekja

Trivedi, M.D. Dr. Trivedi reviewed claimant's history and complaints, and reported physical examination findings to show restricted (but functional) range of motion of the dorsolumbar spine, full range of motion of the cervical spine and full range of motion of the upper extremities and lower extremities. He said also that claimant has no reflex abnormality, muscle spasm, sensory deficit or atrophy, and that x-rays show only mild narrowing at L5 to S1 with no evidence of fracture, dislocation or destructive process. He further noted that claimant walks normally and independently, and concluded that physical examination reveals no evidence of nerve root compression (Exhibit 19).

The first Medical Expert, Frank Cox, M.D., Board-certified in internal medicine, testified at the prior hearing with respect to physical impairment and said that claimant has a history of degenerative disc disease for which she underwent surgery in 1980 and in 1984 (fusion), although findings do not show nerve root involvement. He noted further that MRI scan, CT scan and myelogram (not contained in the record) are reported to be negative, and that x-rays show no significant structural changes of the spine. He concluded that claimant has fibromyalgia and said that there is not neurologic pathway to explain the report of Dr. Weiden (Exhibit 35) and that of the claimant that she has pain from the buttocks radiating up to the neck. He concluded that claimant's impairments, considered singly and in combination, do not meet or equal the requirements of the Listing of Impairments of Appendix 1, Subpart P, Social Security Regulations No. 4, and that the objective records demonstrate no significant impairment. He concluded that claimant should be able to do "at least" medium work as that term is defined in Regulation 404.1567.

Gottfried Spring, M.D., Board-certified in psychiatry, appeared the prior hearing as a Medical Expert concerning mental impairment. He noted that claimant has never had formal, ongoing psychiatric care or treatment with psychotropic medications, although she has participated in a pain management program to which she responded quite well. He indicated that psychological assessments done in conjunction with claimant's evaluation at pain management facilities did not include any specific psychiatric diagnosis, although he indicated that claimant's unrealistic interpretation of physical signs or sensations is consistent with a somatoform disorder, best diagnosed as "psychological factors affecting physical condition." Dr. Spring reviewed further claimant's functional limitations secondary to mental impairment, indicating that claimant has slight restriction of activities of daily living, slight difficulties in maintaining social functioning and few (seldom) deficiencies of

concentration, persistence or pace; and that she has never had an episode of deterioration or decompensation in work or work-like settings. He concluded that claimant's condition does not meet or equal the requirements of the Listing of Impairments of Appendix 1, Subpart P, Social Security Regulations No. 4, and that on a psychiatric basis claimant would be limited to performing low stress, simple tasks (20 CFR 404.1545).

Mary Smith, M. Ed., appeared at the prior hearing as a Vocational Expert and testified that claimant's past work as a factory laborer was light and unskilled and that her work as a quality control inspector was light and semi-skilled (20 CFR 404.1565, 404.1567, 404.1568). A hypothetical question was presented to the Vocational Expert in which she was asked to assume an individual of the claimant's age, education and work experience, having the residual functional capacity to perform medium work (20 CFR 404.1567), with the additional limitations that she could perform low stress, simple, repetitive tasks (20 CFR 404.1545). The Vocational Expert responded that such an individual could perform jobs including dining room attendant, counter supply worker, cook helper, and food counter worker, and testified as to the numbers in which these jobs exist in the economy, which the undersigned finds to be "significant" under Regulation 404.1566.

Additional evidence was obtained in conjunction with the Appeals Council Order. Specifically, although no report has been offered by a physician concerning physical impairment, a series of reports was offered by claimant's current chiropractor, Paul Silcox, D.C. Chiropractor Silcox, who examined the claimant in conjunction with her application for Workers' Compensation payments, reviewed claimant's history and complaints, including that of burning pain in the lumbosacral spine, moving up to the thoracic and cervical spine. He reported pain and limitation of motion of the spine but without dermatomal neurologic deficit, and reported x-rays to show disc space narrowing at L5 to S1 with evidence of surgical procedures performed there subsequently. He recommended that claimant undergo chiropractic treatment indicating: "It is my opinion that as a result of the weaknesses that this patient has as a result the multiple injuries to the lumbar spine the surgeries that have been performed for the purpose of the relief of pain have increased and made permanent the weaknesses there have caused her thoracic spine and even to a certain extent her cervical spine to increase the stress levels there which have put them under a greater load and I do feel that these area are affected now as a result of the injuries and result of the necessary treatment that had to be done at that time for the reason I am requesting that the

allowed condition be extended to the thoracic and cervical spine." [sic]. Chiropractor Silcox opined also that claimant would not be able to seek gainful employment, although he indicated alternately that "she will be able to work at a job which has lifting requirements of 9 lbs. maximum and occasional lifting of an item 1/2 of that weight" [sic] (Exhibit 42).

The undersigned has reviewed the report of Chiropractor Silcox, but concludes that it does not contain any objective, medical evidence, consisting of signs, symptoms, and laboratory findings, showing claimant to have an impairment resulting from anatomical or physiological abnormalities that can be demonstrated to exist by medically acceptable clinical and laboratory diagnostic techniques (20 CFR 404.1508, 404.1528). Thus, the opinion of Chiropractor Silcox is rejected without resort to Regulation 404.1527, as Chiropractor Silcox is not a physician.

Thus, the issue becomes one of mental impairment. In accordance with the Order of the Appeals Council, a psychological evaluation was done by Darlene Barnes, Ph.D. Dr. Barnes reviewed claimant's history and complaints, observing that claimant's personal hygiene and grooming were excellent, although she appeared to be apprehensive, guarded and prone to laughing at times in order to break a sense of tension or anxiety. However, she indicated further that the claimant was apparently cooperative and that her social skills were marked by sophistication and excellence. She reviewed claimant's history and complaints, noting that they involved reading, completing light housework, "praying a lot" and teaching underprivileged children to swim. She also noted that claimant's extensive physical complaints but reported mental status examination to be more significant for the absence of abnormality than for the presence of it. Specifically, she indicated that claimant was fully oriented, and that while her attention and concentration were not good, it was due to preoccupation with (perceived) pain. Dr. Barnes reported no evidence of delusions, hallucinations, paranoid ideation, circumstantial or tangential speech or other indications of thought disorder, although claimant reported feeling depressed "because of constant pain." Dr. Barnes administered MMPI testing that suggested that claimant may be exaggerating her problems, although the content scales on the MMPI were essentially normal. Indeed, Dr. Barnes said that MMPI tests did not note any psychotic thought disorder or characterological disorder. Dr. Barnes diagnosed dysthymia and psychological factors affecting physical condition with histrionic personality traits, indicating that while claimant has severe psychosocial stressors, she has a good to very good abilities to make occupational adjustments, performance adjustments and

personal-social adjustments. Indeed, Dr. Barnes appeared to impose limitations upon the claimant due to physical impairment rather than due to mental impairment (Exhibit 43).

Ten days later, claimant underwent another psychological evaluation, this time by Edward Praul, Ph.D., at the request of claimant's attorney. Dr. Praul reviewed claimant's history and complaints, and administered MMPI testing in support of his opinion that claimant had a somatoform pain disorder and that "her psychological impairment is such that she could not return to any sustained remunitive [sic] employment" (Exhibit 44). However, in this report, Dr. Praul noted that claimant's responses to MMPI testing were of questionable validity. Dr. Praul noted further that claimant "offers a myriad of complaints," and that she also alleged hallucinations despite her denial of having any significant psychological history. Indeed, Dr. Praul (Exhibit 44) offered a far less detailed report than Dr. Barnes, and he did not make mention of objective, medical evidence consisting of signs, symptoms and laboratory findings showing claimant to have a disabling impairment resulting from psychological abnormalities that could demonstrated to exist by medically acceptable clinical and laboratory diagnostic technique (20 CFR 404.1508, 404.1528). Thus, the undersigned finds that greater evidentiary weight is to be afforded the report of Dr. Barnes rather than to the report of Dr. Praul (Exhibits 43 and 44).

This conclusion is bolstered by Medical Expert testimony. Specifically, Frank Cox, M.D., Board-certified in internal medicine, appeared at the current hearing as a Medical Expert with respect to physical impairment, reviewed claimant's history and said that claimant developed back pain at work, following which she underwent disc removal and spinal fusion at L5-S1, although claimant's vertebrogenic disorder did not involve the nerve roots. He noted also that, despite apparently successful surgery, claimant has continued to complain of severe pain spreading from the spine up to the head, which does not follow any neurologic patterns. He said that claimant had residual fibromyalgia, although there is nothing in the record to substantiate any ongoing physical impairment that would account for claimant's complaints. He concluded that claimant's impairments, considered singly and in combination, do not meet or equal the requirements of the Listing of Impairments of Appendix 1, Subpart P, Social Security Regulations No. 4, and that, on an objective basis, there is no significant physical impairment.

Robert Walden, M.D. Board-certified in psychiatry and neurology, appeared at the current hearing as a Medical Expert with respect to mental impairment and said that claimant has a host of psychological aspects, including hysterical traits, that would respond to adequate treatment. He summarized claimant's hysterical traits into a diagnosis of somatoform pain disorder, indicating that claimant has a large emotional component to her physical pain. He also reviewed claimant's functional limitations secondary to mental impairment, indicating that claimant has only slight restriction of activities of daily living and no difficulties in social functioning or deficiencies of concentration, persistence or pace. He indicated further that claimant has never had episodes of deterioration or decompensation in work or work-like settings. This led to his conclusion that claimant does not have work-related limitations secondary to mental impairment.

Karen MacGuffie, M.A., appeared at the hearing as a Vocational Expert and testified that claimant's past relevant work as a hand packer, material handler and inspector was of light exertional requirements and unskilled (20 CFR 404.1565, 404.1567, 404.1568). A hypothetical question was presented to the Vocational Expert in which she was asked to assume an individual of the claimant's age, education and work experience, having the residual functional capacity to perform medium work because of pain (20 CFR 404.1545, 404.1567). The Vocational Expert responded that such an individual could perform her vocationally relevant past work as hand packer, material handler and inspector.

As noted supra, the arguments of counsel have been considered (Exhibits 39 and 44).

In applying sequential evaluation (20 CFR 404.1520), it is found that claimant is not working and has not engaged in substantial gainful activity since April 13, 1988 (20 CFR 404.1520(b)). It is further found that claimant has severe fibromyalgia, status-post remote laminectomy, discectomy and fusion for degenerative disc disease; and somatoform pain disorder (20 CFR 404.1520(c), but that her impairments are not attended by objective findings that meet or equal the requirements of the Listing of Impairments of Appendix 1, Subpart P, Social Security Regulations No. 4 (20 CFR 404.1520(d)).

The undersigned has yet again evaluated claimant's subjective allegations according to the principles and adjudicatory criteria of Social Security Ruling

88-13, which in turn involves thorough, comprehensive, exhaustive review of the objective medical and clinical findings, substantiated medical opinions, testimony of four Medical Experts at two separate hearings, testimony of two Vocational Experts at two separate hearings, arguments of counsel, and reliable lay evidence concerning the claimant's functional capacity, daily activities and treatment modalities. Upon applying this review, the undersigned finds that claimant retains sufficient residual functional capacity to perform her vocationally relevant past work. Thus, her claim remains denied, albeit upon a different regulatory basis (20 CFR 404.1520(e)).

As noted supra, claimant has a history of remote laminectomy and discectomy in 1980 (Exhibit 17) and of spinal fusion in 1984 (Exhibit 14) for degenerative disc disease of the spine.

However, claimant continued working until April 1988, and despite the report of reinjury in April 1988 (Exhibits 33, 34 and 35), the evidence of record does not show evaluation or treatment on an outpatient basis, much less hospitalization or sophisticated work-up at or about that time. Indeed, claimant's recent hospitalization in July 1990 was for hernia repair (Exhibit 36), which was accomplished without residual functional limitations arising therefrom (Exhibit 38).

Claimant has apparently undergone diagnostic studies including MRI scan, CT scan and myelogram all of which have been reported by Drs. Gordon (Exhibit 33) and Weiden (Exhibit 35) to be normal, although the actual diagnostic studies are not contained in the record despite the welter of evidence submitted by counsel, including six exhibits comprising 35 pages that were submitted on the day of the prior hearing (Exhibits 33 through 38).

What is contained in the record establishes that claimant has undergone evaluation and treatment at pain management centers including Central Park West Rehabilitation Center (Exhibit 34) and St. Charles Hospital Pain Management Center (Exhibit 15). Findings from these facilities show claimant to have limitation of the motion of the spine, but no gait antalgia, associated neurologic impairment indicative of nerve root compression, or other conditions that would merit more aggressive therapy.

Claimant has also undergone chiropractic manipulation, as evidenced by a series of internally discrepant reports submitted by David Fields, D.C. Specifically, Chiropractor Fields reported initially that claimant has limitation

of motion of the lumbar spine, but he reported no neurological impairment, joint instability or x-ray evidence showing any abnormalities other than decreased disc space at L5 to S1. He reports that claimant could perform "light to moderate physical work, four to six hours a day" (Exhibit 6), and that claimant has experienced substantial overall improvement in her ability to function (Exhibit 25). However, in a report later recently submitted by counsel, Chiropractor Fields questioned claimant's ability to perform any type of work, although in the same report he opined that claimant can lift up to 20 pounds at a time and walk and stand five hours per day, although the findings he offered in support of his opinion are deficient (Exhibit 27). This, as noted supra, the undersigned rejects Chiropractor Fields' opinion without invoking Regulation 404.1527, as Chiropractor Fields is not a physician.

However, the undersigned does invoke Regulation 404.1527 to reject the opinion of Dr. Weiden, that, in effect, claimant could not return to work. He bases this on claimant's chronic, diffuse fibromyalgia, although this appears to be largely on claimant's symptoms and on his opinion that claimant's "attitude" is "quite poor." He reported claimant to have one inch left thigh atrophy and one/third inch left calf atrophy accompanied by muscle spasms due to fibromyalgia and limitation of motion of the spine, although he reported no reflex abnormality, sensory deficit or motor weakness corresponding to a dermatonal distribution (Exhibit 35), and, as noted by Dr. Cox, there is no neurological pathway in the human anatomy to explain pain radiating from the buttocks up to the neck (testimony supra). Indeed, no such findings are offered by Dr. Gordon, who also noted that diagnostic studies (not contained in the record) are negative for radiculopathy or for a surgical problem and who reported that claimant has trigger point tenderness and moderately restricted lumbar flexion and extension but normal lateral bending, full range of motion of all other joints without synovitis, and no neurologic impairment. This led to Dr. Gordon's opinion that claimant's pain symptoms, combined with associated anxiety, depression, irritable bowel syndrome and sleep disturbance, are consistent with fibrositis, in light of a relatively benign-appearing exam (Exhibit 33).

Furthermore, as noted supra, a thorough consultative examination, done by Rekja Trivedi, M.D., showed no atrophy whatsoever; no reflex abnormality, sensory deficit, motor weakness or spasm; and only mild to moderate limitation of motion of the dorsolumbar spine with full range of motion of the cervical spine, upper extremities and lower extremities. He further reported claimant to have a normal, unassisted gait without signs of joint instability or

inflammation. He said further that x-rays show only mild narrowing at L5 to S1 with no fracture, dislocation or disruptive process, leading to his conclusion that claimant has no evidence of nerve root compression (Exhibit 19).

Additionally, as noted supra, the report of Chiropractor Silcox is noteworthy for the lack of objective, medical evidence consisting of medical signs, symptoms, and laboratory findings showing claimant to have a disabling impairment resulting from anatomical or physiological abnormalities that could be demonstrated to exist by medically acceptable clinical and laboratory diagnostic techniques (20 CFR 404.1508, 404.1528). Thus, the opinion of Chiropractor Silcox is rejected without resort to Regulation 404.1527, as Chiropractor Silcox is not a physician (Exhibit 42).

Additionally, as noted supra, greater evidentiary weight is accorded to the consultative psychological unit evaluation done by Dr. Barnes (Exhibit 43) than to the evaluation done by Dr. Praul (Exhibit 44), as Dr. Barnes obtained valid MMPI results (Dr. Praul did not), and since Dr. Barnes' consultative report offers far more detailed, specific, medical evidence consisting of medical signs, symptoms and laboratory findings showing claimant to have good to very good/unlimited capacities in making occupational adjustments, performance adjustments, and personal-social adjustments (Exhibit 43).

This is corroborated by a Medical Expert testimony obtained at the Supplemental Hearing, which establishes that claimant does not have severe, work-related functional limitations secondary to mental impairment (supra).

Symptoms such as pain are the individual's own perceptions of the effects of a physical or mental impairment(s). Because of their subjective characteristics and the absence of reliable techniques for measurement, symptoms are difficult to prove or to or quantify. The guidelines for evaluation of pain are set forth in Social Security Ruling 88-13 and Regulation 20 CFR 404.1529. The claimant's allegations in this regard are entitled to perceptible weight where they are properly and adequately documented by the medical evidence. Objective evidence such as muscle atrophy from non-use, muscle spasm reduced joint motion, and sensory and motor disruption should be considered where applicable. However, where the alleged or reported symptoms exceed the expected level of pain and/or dysfunction, it is important to consider such factors as (1) nature, location, onset, duration, frequency, radiation and intensity of the pain; (2) precipitating and aggravating factors such as movement or activity; (3) type, dosage, effectiveness, and adverse side-effects

of pain medication; (4) treatment for relief of pain other than medication; (5) functional restrictions; and, (6) the claimant's level of activities. It is useful at times to consider observations of the claimant by the Administrative Law Judge at the hearing and by examining doctors. Finally, the credibility of the claimant should also be taken into consideration.

As noted supra, the record contains none of the indicia of physical impairment that would support claimant's subjective allegations that, in effect, she has debilitating, devastating, relentless, incapacitating, rending pain. Furthermore, as noted supra, claimant said initially that she took no medications (Exhibit 13), then said that she took Demerol and Ceclor (Exhibit 32) and then testified at the hearings that she took no prescription medication until recently (testimony). Claimant's treatment has been conservative; her back surgeries were in 1980 and in 1984, long before her alleged onset of "disability" (Exhibits 14 and 17). The claimant has undergone evaluation and treatment at local pain management centers (Exhibits 15 and 24) and has received chiropractic manipulation (Exhibits 16, 25 and 37) with at least some success. Claimant acknowledged also that she last used a back brace about a year ago and that she has a TENS unit but cannot put it on herself.

Additionally, claimant acknowledged that she maintains her personal needs; does housework including cooking, washing dishes, dusting, sweeping, vacuuming, washing clothes and making the bed; that she goes shopping and does yardwork; and that she goes for walks and drives, gets along with other people well. Claimant acknowledge further that she has never had formal mental health care or received psychotropic medication. Claimant acknowledges that she visits friends, goes out to dinner, writes as a hobby, and has occasionally gone swimming, and recently went to New York City to accept an award for her writing.

At the Supplemental Hearing claimant modified her allegations, indicating that she took no prescription medication prior to March 26, 1992. She also did not indicate that her current medication, including Premarin, Zoloft and Zantac, were ineffectual or resulted in adverse side-effects of functional significance. Nevertheless, claimant alleged relentless, debilitating, excruciating, devastating, rending pain, despite the lack of objective findings and despite the fact that her allegations of pain radiating from the low back up to the head do not have an anatomical basis. Furthermore, the claimant acknowledged that she can walk four miles, stand and sit up to one hour at a time, lift fifteen pounds and perform a wide range of daily activities

including maintaining her personal needs, cooking, making the bed, going shopping when she needs to, walking and riding, reading the Bible, engaging in creative writing, riding a bicycle and going out socially.

Accordingly, considering claimant's subjective allegations yet again according to the principles of Social Security Ruling 88-13, which involves thorough, comprehensive, exhaustive review of the objective medical and clinical findings, substantiated medical opinions, testimony of four Medical Experts at two hearings, testimony of two Vocational Experts at two hearings, arguments of counsel (Exhibits 39 and 44) and claimant's own acknowledgements concerning her functional capacity, daily activities and treatment modalities, the undersigned finds that claimant's allegations of disabling pain and limitation of function are distinctly not credible; and that, at a minimum, she could perform a full range of work of medium exertional requirements (20 CFR 404.1545, 404.1567).

Furthermore, supplemental Vocational Expert testimony, supra, establishes that claimant's past relevant work as a hand packer, material handler and inspector did not require her to exceed these limitations (20 CFR 404.1565).

Therefore, since the claimant's impairments do not prevent the claimant from performing her vocationally relevant past work, she is "not disabled" (20 CFR 404.1520(e)). It is found that the claimant was not under a "disability" as defined in the Social Security Act, at any time through the date of this decision.

FINDINGS

After careful consideration of the entire record, the Administrative Law Judge makes the following findings:

1. The claimant met the disability insured status requirements of the Act on April 13, 1988, the date the claimant stated she became unable to work, and continues to meet them through September 30, 1993.

2. The claimant has not engaged in substantial gainful activity since April 13, 1988.

3. The medical evidence establishes that the claimant has severe fibromyalgia, status-post remote laminectomy, discectomy and fusion for degenerative disc disease; and somatoform pain disorder, but that she does not have an impairment or combination of impairments listed in, or medically equal to one listed in to Appendix 1, Subpart P, Social Security Regulations No. 4.

4. Claimant's allegations of disabling, relentless, excruciating, debilitating, rending pain and limitation of function are distinctly not credible, and are not supported by substantial evidence in the form of objective medical and clinical findings, substantiated medical opinions, testimony of four Medical Experts at two hearings, testimony of two Vocational Experts at two hearings, arguments of counsel, and by claimant's own acknowledgements concerning her functional capacity, daily activities and treatment modalities (Social Security Ruling 88-13). Claimant does not have pain or limitation of function due to medically determinable impairments that are of a level of severity that would preclude her from performing her vocationally relevant past work.

5. The claimant has the residual functional capacity to perform a full range of work of medium exertional requirements (20 CFR 404.1545, 404.1567).

6. The claimant's past relevant work as a hand packer, material handler and inspector do not require her to exceed these limitations (20 CFR 404.1565).

7. The claimant's impairments do not prevent the claimant from performing her vocationally relevant past work.

8. The claimant was not under a "disability," as that term is defined in the Social Security Act, at any time through the date of this decision (20 CFR 404.1520(e)(f)).

DECISION

It is the decision of the Administrative Law Judge that, based on the application filed on September 29, 1989, the claimant is not entitled to a Period of Disability or Disability Insurance Benefits under Sections 216(i) and 223, respectively, of the Social Security Act, as amended.

Richard C. Mesrobian
Administrative Law Judge

Dated: May 6, 1992

ROM/ch

OHA PSYCHIATRIC REVIEW TECHNIQUE FORM

Name: Susan L. Fields SSN: 290-42-6916

Assessment is for: Current Evaluation

Administrative Law Judge's Signature Date

5/6/92

I. MEDICAL SUMMARY

A. Medical Disposition(s): Impairment(s) Not Severe

B. Based upon Category(ies): 12.07

II. Reviewer's Notes (Does not apply to OHA)

III. DOCUMENTATION OF FACTORS THAT EVIDENCE THE DISORDER (Evaluation of the existence of a sign or symptom CLUSTER or SYNDROME for the Listed Disorder.)

PRESENT	ABSENT			
[ ]	[x]	A.	12.02	Organic Mental Disorders
[ ]	[x]	B.	12.03	Schizophrenic, Paranoid and other Psychotic Disorders
[ ]	[x]	C.	12.04	Affective Disorders
[ ]	[x]	D.	12.05	Mental Retardation and Autism
[ ]	[x]	E.	12.06	Anxiety Related Disorders
[x]	[ ]	F.	12.07	Somatoform Disorders
[ ]	[x]	G.	12.08	Personality Disorders
[ ]	[x]	H.	12.09	Substance Addiction Disorders

F. 12.07 Somatoform Disorders - Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms, as evidenced by at least one of the following:

PRESENT-ABSENT-INSUFFICIENT EVIDENCE

1.	[ ]	[x]	[ ]	A history of multiple physical symptoms of several years duration beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly
2.	[x]	[ ]	[ ]	Persistent nonorganic disturbance of one of the following:
				a. [ ] Vision, or
				b. [ ] Speech, or
				c. [ ] Hearing, or
				d. [ ] Use of a limb, or
				e. [ ] Movement and its control (e.g., coordination disturbances, psychogenic seizures, akinesia, dyskinesia), or
				f. [x] Sensation (e.g., diminished or heightened)
3.	[x]	[ ]	[ ]	Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury
4.	[x]	[ ]	[ ]	Other: Somatoform Pain Disorder

IV. RATING OF IMPAIRMENT SEVERITY

A. "B" Criteria of the Listings

The following functional limitations (which apply to paragraph B of listing 12.02-12.04 and 12.06-12.08 and paragraph D of 12.05) exist as a result of the individual's mental disorder(s).

NOTE: Items 3 and 4 below are more than measures of frequency. Duration and effects of the deficiencies (item 3) or episodes (item 4) are discussed in the decision.

Listing(s) under which the items below are being rated: 12.07

FUNCTIONAL LIMITATION AND DEGREE OF LIMITATION

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1. Restrictions of Activities of Daily Living:

None [ ] Slight [x] Moderate [ ] Marked* [ ] Extreme [ ] Insuff Evid [ ]

---

2. Difficulties in Maintaining Social Functioning:

None [x] Slight [ ] Moderate [ ] Marked* [ ] Extreme [ ] Insuff Evid [ ]

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3. Deficiencies of Concentration, Persistence or Pace Resulting in Failure to Complete Tasks in a Timely Manner (in work settings or elsewhere):

Never [x] Seldom [ ] Often [ ] Frequent* [ ] Constant [ ] Insuff Evid [ ]

---

4. Episodes of Deterioration or Decompensation in Work or Work-Like Settings Which Cause the Individual to Withdraw from that Situation or to Experience Exacerbation of Signs and Symptoms (which may Include Deterioration of Adaptive Behaviors):

Never [x] Once/Twice [ ] Repeated*(3+) [ ] Continual [ ] Insuff Evid [ ]

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*Degree of limitation that satisfies the Listings: Extreme, Constant and Continual also satisfy that requirement.

B. Summary of Functional Limitation Rating for "B" Criteria

NO. OF FUNCTIONAL LIMITATIONS MANIFESTED AT THE LISTING LEVEL: [0] (The number must be at least 2 to satisfy the requirements of paragraph B in Listings 12.02, 12.03, 12.04 and 12.06 and paragraph D in 12.05; and at least 3 to satisfy the requirements in paragraph B in Listings 12.07 and 12.08.)

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
WESTERN DIVISION

Susan L. Fields,

92CV 7670

Plaintiff

v.

Magistrate's Report and Recommendation

Secretary of Health and Human Services,

Defendant

This is a social security case which has been referred to the undersigned for a Magistrate's Report and Reconsideration. Pending are cross motions for summary judgment. For the reasons stated below, it is recommended that plaintiff's motion be granted, and defendant's motion be denied.

Plaintiff filed an application for disability insurance benefits on September 29, 1989, alleging that she has been disabled since April 13, 1988, due to back pain. This application was denied initially and upon reconsideration. Following an administrative hearing, an Administrative Law Judge (ALJ) issued a decision denying plaintiff's claim on November 26, 1990. On review, the Appeals Council remanded the case to the ALJ in order to obtain additional medical and psychological evidence. A second administrative hearing was held on April 23, 1992. Following that hearing, the ALJ again issued an decision denying plaintiff's claim on May 6, 1992. The Appeals Council denied plaintiff's request for review, rendering the ALJ's decision the final decision of the Secretary for purposes of judicial review. Subsequently, plaintiff commenced the present action pursuant to 42 U.S.C. §405(g).

Under 42 U.S.C. §405(g), judicial review of the Secretary's decision is limited to determining whether the decision is supported by substantial evidence. The reviewing court "may not try the case de novo, nor resolve conflicts in evidence, nor decide questions of credibility." *Garner v. Heckler,*

745 F.2d 383,387 (6th Cir. 1984). If supported by substantial evidence, the findings of the Secretary are to be given conclusive effect. 42 U.S.C. §405(g).

Substantial evidence in this context is defined as "'such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.' It is more than a scintilla but less than a preponderance." *Gaffney v. Bowen*, 825 F.2d 98, 100 (6th Cir. 1987) (quoting *Richardson v. Perales*, 402 U.S. 389, 401 (1971)). The existence of substantial evidence is determined by viewing the record as a whole, *Allen v. Califano*, 613 F.2d 139, 145 (6th Cir. 1980), taking "into account whatever in the record fairly detracts from its weight." *Beavers v. Secretary of H.E.W.*, 577 F.2d 383, 387 (6th Cir. 1978). If supported by substantial evidence, the Secretary's decision must be affirmed, even if a reviewing court would decide the matter differently, *Kinsella v. Schweiker*, 708 F.2d 1058, 1059 (6th Cir. 1983), or if the claimant's position is supported by substantial evidence also. *Mullen v. Bowen*, 800 F.2d 535, 545 (6th Cir. 1986).

To establish entitlement to disability benefits, a claimant must prove that he is incapable of performing substantial gainful activity due to a medically determinable physical or mental impairment which can be expected to result in death or to last for a period of at least twelve months. 42 U.S.C. § 423(d)(1)(A); *Murphy v. Secretary of H.H.S.*, 801 F.2d 182, 183 (6th Cir. 1986); *Richardson v. Heckler*, 750 F.2d 506, 509 (6th Cir. 1984). The claimant must how that his impairment results from anatomical, physiological or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. 42 U.S.C. §§ 423(d)(3), 1382(a)(3)(C); 20 C.F.R. §§404.1513, 404.1528, 416.913, 416.928.

The ALJ found that plaintiff will continue to meet the disability insured status requirements of the Social Security Act through September 30, 1993. The ALJ also found that plaintiff had not engaged in substantial gainful activity since April 13, 1988. The ALJ found that plaintiff suffered from severe fibromyalgia, status-post remote laminectomy, discectomy and fusion for degenerative disc disease, and somatoform pain disorder. However, none of these impairments, alone or in combination, was found to meet or equal the requirements of an impairment listed in 20 C.F.R. § 404, Subpart P, Appendix 1. The ALJ found that plaintiff's subjective complaints of "disabling, relentless, excruciating, debilitating, rending pain and limitation of function are distinctly not credible, and are not supported by substantial evidence in the form of objective medical and clinical findings, substantiated medical opinions,

testimony of four medical experts at two hearings, testimony of two Vocational Experts at two hearings, arguments of counsel, and by claimant's own acknowledgments concerning her functional capacity, daily activities and treatment modalities." (Tr. 32).

The ALJ determined that plaintiff retained the residual functional capacity (RFC) to perform a full range of medium work. The ALJ also determined that plaintiff could still perform past relevant work as a hand packer, material handler and inspector. Consequently, the ALJ found that plaintiff was not disabled within the meaning of the Social Security Act.

Plaintiff contends that the ALJ erred in weighing the opinions of her treating physicians. The medical diagnoses and opinions of treating physicians are accorded substantial deference, and if uncontradicted, complete deference. *Harris v. Heckler*, 756 F.2d 431, 435 (6th Cir. 1985). Such deference is granted only if the treating physician's opinion is supported by sufficient medical data. Id. An ALJ must set forth reasons for rejecting the opinion of a treating physician, and the opinion of a Medical Advisor, without more, is an insufficient basis for doing so. *Shelman v. Heckler*, 821 F.2d 316, 320-321 (6th Cir. 1987). Where a Medical Advisor's opinion is based on conflicts and inconsistencies in the medical evidence, however, an ALJ does not err in accepting the Medical Advisor's opinion. *Hale v. Secretary of H.H.S.*, 816 F.2d 1078, 1083 (6th Cir. 1987).

Plaintiff contends that the ALJ erred in discounting the opinions of her treating chiropractors, David Fields and Paul Silox. Both chiropractors opined that plaintiff was incapable of performing substantial gainful activity at any exertional level. (Tr. 334, 358). According to 20 C.F.R. §404.1513, a chiropractor is not an acceptable medical source. Although plaintiff may offer a chiropractor's opinion of her ability to work, the ALJ is not required to afford the opinion substantial deference because it is not the opinion of a treating physician. The ALJ was entitled to discount plaintiff's treating chiropractors' opinions.

Plaintiff also contends that the ALJ erred in rejecting the opinion of Dr. Edward Praul, Ph.D., a psychologist who examined plaintiff at the request of her attorney. (Tr. 376). This contention lacks merit. A treating physician is a physician who has "treated a patient over a period of time or who [has been] consulted for purposes of treatment." *Allen v. Califano*, 613 F.2d 139,

145 (6th Cir. 1987). Because Dr. Praul was consulted in furtherance of plaintiff's disability claim, rather than for purposes of treatment, the ALJ did not err in discounting his opinion.

Plaintiff also contends that the ALJ erred in accepting the testimony of the Vocational Experts (VEs)[1] Defendant correctly points out that the ALJ reached his decision regarding plaintiff's disability at step four of the sequential analysis. At this stage of the sequential analysis, plaintiff has the burden of proving that she can no longer perform her past relevant work. *Villarreal v. Secretary of H.H.S.*, 818 F.2d 461, 462 (6th Cir. 1987). It is not necessary for the Secretary to obtain VE testimony at step four.

In the present case, the ALJ obtained VE testimony at both hearings. His decision is based,in part, on the second VE's testimony relating to plaintiff's past relevant work. However, the VE's testimony in response to the ALJ's hypothetical question played no part in the ALJ's disability determination. Consequently, any deficiency in the hypothetical question is harmless error.

Finally, plaintiff argues that the ALJ erred in finding plaintiff capable to perform her past relevant work. Specifically, plaintiff contends that the ALJ erred in rejecting her subjective complaints of pain and in finding her capable of a full range of medium work. In assessing plaintiff's pain, the ALJ made a very detailed finding regarding plaintiff's credibility. (Tr. 32). "Since credibility, especially with alleged pain, is crucial to resolution of the claim, the ALJ's opportunity to observe the demeanor of the claimant 'is invaluable, and should not be discarded lightly.'" *Kirk v. Secretary of H.H.S.*, 667 F.2d 524, 538 (6th Cir. 1981) (quoting *Beavers v. Secretary of H.E.W.*, 577 F.2d 383, 387 (6th Cir. 1978).

Subjective complaints of pain and other symptoms are evaluated under a two-prong test. *Blankenship v. Bowen*, 874 F.2d 1116, 1123 (6th Cir. 1989). First, there must be objective medical evidence of an underlying evidence which confirms the severity of the alleged symptom or evidence that the underlying medical condition is of such severity that it can reasonably be

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[1]A different vocational expert testified at each of the administrative hearings.

expected to produce the alleged symptoms. *McCormick v. Secretary of H.H.S.*, 861 F.2d 998, 1002-1003 (6th Cir. 1988).

In the present case, the Secretary admits that plaintiff has satisfied the first prong of the test. However, plaintiff has failed to satisfy either of the alternatives on the second prong of the test. Although plaintiff presented a great deal of evidence indicating that she suffers from the underlying medical conditions of fibromyalgia and somatoform pain disorder, both of which are characterized by pain, she has not presented any evidence that her pain is severe or disabling. Moreover, nothing in the record indicates that these conditions were the kind that would be expected to produce severe disabling pain. Consequently, the ALJ did not err in finding that plaintiff's complaints of pain and functional limitation were not credible.

Plaintiff also contends that the ALJ erred in finding that she could perform a full range of medium work. The medical evidence of record indicates that plaintiff has undergone laminectomies at L4-L5 and L5-S1, and spinal fusion at L5-S1. (Tr. 225, 248, 256). A examination by Dr. Gordon revealed that plaintiff had "trigger point tenderness as noted in the trapezius, neck extensors, lumbar and thoracic paraspinous muscles." (Tr. 313). Dr. Gordon also noted that plaintiff's lumbar range of motion was moderately restricted. Id. After an examination conducted on June 1, 1990, Dr. Weiden concluded that plaintiff had "diffuse generalized fibromyalgia, with severe muscle spasm from the neck down to her low back gluteal regions." (Tr. 318). He also found that plaintiff had a markedly reduced range of motion in her lower back. (Tr. 319).

Although the MA testified at the first hearing that plaintiff was capable of performing medium work, at the second hearing he testified that:

> Ms. Fields initially in 1980 developed back pain while at work. She had a laminectomy done with the removal of parts of two discs. Interestingly enough, neither of them involved any of the nerve roots. The pain recurred in four years and the physician then did a spinal fusion over those L-5 and S-1, and since that time she has had more pain and the record indicates the pain has spread from the lower end of the spine up to the head.

(Tr. 160)(emphasis added). This testimony is corroborated by the results of numerous examinations and tests. The ALJ did not ask the MA at either hearing whether plaintiff had any non-exertional impairments. Moreover the ALJ did not ask the MA at the second hearing whether his opinion of plaintiff's RFC had changed in view of the additional evidence presented. The record clearly indicates that plaintiff suffers from pain and limited range of motion in her lumbar spine. These conditions would prevent her from doing a full range of medium work. Consequently, the ALJ erred in finding that she could perform a full range of medium work.

For all the foregoing reasons, it is therefore

RECOMMENDED THAT plaintiff's motion for summary judgment be granted, and defendant's motion for summary judgment be denied.

United States Magistrate Judge

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO, WESTERN DIVISION

Susan L. Fields,

JUDGMENT IN A CIVIL CASE

v.

Secretary of Health and Human Services,

CASE NUMBER: 3:92CV7670

☐ **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

■ **Decision by Court.** This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

that plaintiff's motion for summary judgment is hereby denied; and it is FURTHER ORDERED that defendant's motion for summary judgment is hereby granted. Case dismissed.

UNITED STATES DISTRICT JUDGE

November 30, 1993
Date

GERI M. SMITH
Clerk

Carol J. (illegible)
(By) Deputy Clerk

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
WESTERN DIVISION

Susan L. Fields,

Plaintiff — Case No. 3:92CV7670

vs.

Secretary of Health and
Human Services,

Defendant — OPINION AND ORDER

POTTER, J.:

This cause was transferred to the United States Magistrate for a Report and Recommendation. Magistrate James G. Carr filed his Report and Recommendation on July 26, 1993. The Court has received defendant's objections and plaintiff's response.

This is a social security case in which plaintiff appeals the Secretary's decision that she is ineligible for benefits. Plaintiff's application for disability insurance benefits was denied following an administrative hearing by an Administrative Law Judge (ALJ). The case was remanded to the ALJ by the Appeals Council to obtain additional evidence and a subsequent hearing was held. Following that hearing, the ALJ again denied plaintiff's claim, and the Appeals Council denied plaintiff's request for review. Plaintiff then commenced this action for judicial review of the Secretary's decision pursuant to 42 U.S.C. §405(g).

The reviewing court "may not try the case de novo, nor resolve conflicts in evidence, nor decide questions of credibility. *Garner v. Heckler*, 745 F.2d 383, 387 (6th Cir. 1984). The Secretary's factual determinations are therefore binding on this Court if supported by substantial evidence. 42 U.S.C. § 405(g). Substantial evidence has been defined as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Lashley*

v. Secretary of Health & Human Services, 708 F.2d 1048, 1053 (6th Cir. 1983), citing *Richardson v. Perales*, 402 U.S. 389, 401 (1971).

As the Magistrate properly observed:

> To establish entitlement to disability benefits, a claimant must prove that he is incapable of performing substantial gainful activity due to a medically determinable physical or mental impairment which can be expected to result in death or to last for a period of at least twelve months. 42 U.S.C. §423 (d)(1)(A); *Murphy v. Secretary of H.H.S.*, 801 F.2d 182, 183 (6th Cir. 1986); *Richardson v. Heckler*, 750 F.2d 506, 509 (6th Cir. 1984). The claimant must show that his impairment results from anatomical, physiological or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. 42 U.S.C. §§423(d)(3), 1382(a)(3)(C); 20 C.F.R.§§ 404.1513, 404.1528, 416.913, 416.928.

Report and Recommendation at p. 3.

The ALJ found that plaintiff retained the residual functional capacity (RFC) to perform a full range of medium work and also that she could still perform some of her past relevant work. The ALJ therefore determined that plaintiff was not disabled within the meaning of the Social Security Act.

The Report and Recommendation found that each of the elements of the Secretary's determination were supported by substantial evidence, with the exception of the Secretary's finding that plaintiff could perform a full range of medium work. The Magistrate would overturn the Secretary's determination as not supported by substantial evidence. The Magistrate found that the ALJ should have inquired at the second hearing whether the medical advisor's opinion of plaintiff's RFC had changed in view of the additional evidence presented. Further, the Magistrate determined that he ALJ should have asked the medical advisor whether plaintiff had any nonexertional limitations. Defendant objects generally to the finding that the administrative determination is not supported by substantial evidence and specifically to the findings that the ALJ should have asked additional questions.

At the second hearing, in response to questioning from the ALJ, the medical advisor testified as follows:

> Your Honor, Ms. Fields initially in 1980 developed back pain while at work. She had a laminectomy done with the removal of parts of two discs. Interestingly enough, neither of them involved any of the nerve roots. The pain recurred in four years and the physician then did a spinal fusion over those L-5 and S-1, and since that time she has had more pain and the record indicates the pain has spread from the lower end of the spine up to the head. It is -- does not follow any recognized neurological pathways. The difficulties as described are quite typical of what is now referred to as fibromyalgia. Originally it was called fibromyositis. And I think there have been some other terms. There is in fact no -- nothing in the record to substantiate any significant physical impairment that would account for this diffuse and rather -- how can I say it -- it spreads back, it, it jumps around, a rather unusual distribution of pain even for fibromyalgia.
>
> . . .
>
> Your Honor, I can find no significant physical impairment that would limit her activities other than her subjective pain.

Tr. at pp. 160-161. In addition, a second medical advisor testified that none of plaintiff's mental impairments, singularly or in combination, rise to the level required by the listings of functional limitations. The examination by the ALJ of the other medical examiner sets forth:

> Q And -- but what I'm particularly interested in, Doctor, is in the -- in employment? Would there be any type of stressor or situation that she should avoid?
>
> A I can't really think of anything that she really couldn't handle. She's -- as she said herself, she handles stress quite well, and I think that's basically true.

Tr. at p. 173.

The Court finds that the ALJ reasonably evaluated the medical advisor's testimony in determining that plaintiff had the RFC to perform a full range of medium work. The Court therefore finds that the ALJ's determination was reached in accordance with applicable law and was supported by substantial evidence.

Upon a de novo review of the Magistrate's Report and Recommendation, the record in this case, and said objections, this Court finds that the objections

are well taken.[1] To the extent the Report and Recommendation would overturn the Secretary's determination that plaintiff retained the RFC to perform a full range of medium work, the Report and Recommendation shall not be adopted as the Order of this Court.

THEREFORE, for the foregoing reasons, good cause appearing, it is

ORDERED that the Report and Recommendation is adopted in part as the Order of this Court; and it is

FURTHER ORDERED that plaintiff's motion for summary judgment be, and hereby is, DENIED; and it is

FURTHER ORDERED that defendant's motion for summary judgment be, and hereby is, GRANTED.

John W. Potter
Sr. United States District Judge

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[1]In her response to defendant's objections, plaintiff asserts that the review of the Report and Recommendation should be conducted on a clearly erroneous standard. Plaintiff further argues that the objections were not timely filed and that the Court is therefore not required to conduct a de novo review. Both of these assertions are without merit. In an order entered October 18, 1993, defendant's objections were deemed timely filed, and the court must therefore conduct a de novo review pursuant to L.R. 5:3.1(b) and Fed. R. Civ. P. 72(b).